

AUTHORIZATION FOR TREATMENT

I authorize treatment of the patient named herein. I understand that therapy evaluations and treatment may potentially cause or aggravate symptoms, and I give my consent for the therapist to perform evaluations and treatment as he or she deems necessary.

PATIENT INFORMATION CONSENT

I have received, read and fully understand Joint Effort's Notice of Information Practices. I understand that Joint Effort may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Joint Effort will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Joint Effort's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

AUTHORIZATION TO PAY BENEFITS

I, _____, agree to the terms stated above. I hereby authorize and instruct my insurance carrier to make payment of medical benefits to Joint Effort Physical Therapy LLC for therapy services rendered, and that no payment be made payable to the insured.

Patient or Responsible Party: _____ *Date:* _____

WORKER'S COMPENSATION PATIENTS

I understand that if this medical condition is found not to be work related, I will be responsible for prompt payment for medical treatment.

Patient or Responsible Party: _____ *Date:* _____

COMMUNICATION CONSENT

- A. I give Joint Effort Rehab LLC permission to leave detailed phone messages regarding my medical and/or billing information on:

My home phone voice mail	# _____	Medical Care _____	Billing Acct _____
My cell phone voice mail	# _____	Medical Care _____	Billing Acct _____
My work phone voice mail	# _____	Medical Care _____	Billing Acct _____
My spouse (name)	_____	Medical Care _____	Billing Acct _____
Other (name)	_____	Medical Care _____	Billing Acct _____

Patient or Responsible Party: _____ *Date:* _____

- B. I wish to be contacted personally and do not authorize Joint Effort Rehab LLC to leave detailed messages or discuss my care or billing account with anyone other than myself.

Patient or Responsible Party: _____ *Date:* _____

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